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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08218

## CERTIFICATE OF DEATH

Reg. Dist. No. 105

8242

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <i>Rural - Waldorf</i>		<i>life</i>		TOWN <i>Rural - Waldorf</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Berry Road</i>				STREET ADDRESS (If rural give location) <i>Berry Road</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>JUANITA</i> (Middle) <i>S.</i> (Last) <i>BERRY</i>				(Month) <i>Aug</i> (Day) <i>2</i> (Year) <i>1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>white</i>	<i>widow</i>	<i>May 24, 1886</i>	<i>70</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>Home</i>		<i>unk.</i>		<i>USA</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>DON SANZIO</i>				<i>ELLA HUBERT</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>NO</i>		<i>13763 6932A</i>		<i>MRS Vivian B. Norris Waldorf Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
904.0 IMMEDIATE CAUSE (A)				<i>Myocardial Failure</i>			
ANTECEDENT CAUSE(S) DUE TO				<i>Fractured Rt Hip</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<i>Fractured Rt Hip</i>			
STATING UNDERLYING CAUSE LAST. DUE TO				<i>Fractured Rt Hip</i>			
(C)				<i>Fractured Rt Hip</i>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<i>Infected Bed Sores</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		INTERVAL BETWEEN ONSET AND DEATH	
<i>Dec 3, 1955</i>		<i>Fractured Rt Hip</i>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<i>6 mo</i>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<input type="checkbox"/>		<i>Home</i>		<i>Rural - Berry Rd - Waldorf - Charles Co. Md</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<i>Dec 1, 1955 - 9:30 PM</i>		<i>at work</i>		<i>Fell at home</i>			
22. I hereby certify that I attended the deceased from <i>10/19/55</i> , to <i>8/3/56</i> , that I last saw the deceased alive on <i>7/29/55</i> , 19 <i>55</i> , and that death occurred at <i>12:15 PM</i> , from the causes and on the date stated above.							
SIGNATURE <i>Vahel M. Bern</i>				ADDRESS (Street, city, town, state) <i>Aguassene Md</i>		DATE SIGNED <i>8/3/56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>BURIAL</i>		<i>8-4-56</i>		<i>St Peters</i>		<i>Waldorf Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>AUG 5 1956</i>		<i>M. L. Monroe</i>		<i>Hunt Funeral Home</i>		<i>Waldorf Md.</i>	



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INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8243

## CERTIFICATE OF DEATH

08219

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		STATE <u>Maryland</u>		COUNTY <u>Charles</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>La Plata</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bryans Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Albert</u>		(Middle) <u>Marvin</u>		(Last) <u>Betts</u>		(Month) (Day) (Year) <u>August 10, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 25, 1901</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tenant Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William Thomas Betts</u>				14. MOTHER'S MAIDEN NAME <u>Mary Eliza Evans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mary Morton, Bryans Road, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>8-10-56</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>						<u>??</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-10-56</u> , to <u>8-10-56</u> , that I last saw the deceased alive on <u>8-10-56</u> , and that death occurred at <u>12</u> M. from the causes and on the date stated above.							
SIGNATURE <u>E. J. Tedelen</u> M.D.				ADDRESS (Street, city, town, state) <u>12</u> DATE SIGNED <u>8-10-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried at Bryans Road</u>		DATE THEREOF <u>8/12/56</u>		NAME OF CEMETERY OR CREMATORY <u>New Bethel</u>		LOCATION (City, town, or county) (State) <u>Wilton, Va.</u>	
24. REC'D BY REGISTRAR <u>AUG 13 1956</u>		REGISTRAR'S SIGNATURE <u>Galia Poy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Archibald Funeral Home, La Plata, Md.</u>		ADDRESS	

# CERTIFICATE OF DEATH

100

1. PLACE OF DEATH

2. COUNTY

3. CITY

4. STREET

5. APARTMENT

6. ROOM

7. BUILDING

8. DISTRICT

9. ZIP CODE

10. MEDICAL CERTIFICATION

11. SIGNATURE

12. DATE

13. TIME

14. CAUSE OF DEATH

15. MANNER OF DEATH

16. PLACE OF BURIAL

17. NAME OF BURIAL PLACE

18. ADDRESS OF BURIAL PLACE

19. CITY OF BURIAL PLACE

20. STATE OF BURIAL PLACE

21. ZIP CODE OF BURIAL PLACE

22. SIGNATURE

23. DATE

24. TIME

25. CAUSE OF DEATH

26. MANNER OF DEATH

27. PLACE OF BURIAL

28. NAME OF BURIAL PLACE

29. ADDRESS OF BURIAL PLACE

30. CITY OF BURIAL PLACE

31. STATE OF BURIAL PLACE

32. ZIP CODE OF BURIAL PLACE

BUREAU V. E.

AUG 13 1956

RECEIVED

*Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8244

## CERTIFICATE OF DEATH

08220

Reg. Dist. No. 100

1. PLACE OF DEATH o. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newport</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newport</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WASHINGTON</b> First <b>PATTERSON</b> Middle <b>BOWLING</b> Last				4. DATE OF DEATH <b>AUG</b> Month <b>27</b> Day <b>19</b> Year <b>56</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 FEB 1969</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Wallace Bowling</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Dolman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Walter W. Bowling</b> Address <b>Newport, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> (c) <b>age</b>						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Apr 17, 1956</b> , to <b>8-27, 1956</b> , that I last saw the deceased alive on <b>8-27, 1956</b> , and that death occurred at <b>900 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J M Johnson</b>				ADDRESS (Street, city or town, state) <b>La Plata</b> DATE SIGNED <b>8-27-56</b>			
PHYSICIAN'S NAME (Type) <b>E</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 30 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dentsville</b>		22d. LOCATION (City, town, or county) (State) <b>DENTSVILLE MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home</b>				24a. REC'D BY REGISTRAR <b>SEP 4 1956</b> 24b. REGISTRAR'S SIGNATURE <b>W. Hills Poy</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1921		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
APRIL 4, 1968		MEMPHIS, TENNESSEE		HEART DISEASE		SUICIDE		CORONARY ARTERY DISEASE		DR. JAMES EARL RAY	
TIME OF DEATH		HOURS		MINUTES		SECOND		TEMPERATURE		PULSE	
10:00 AM		10		00		00		98.6		60	
DATE OF BURIAL		PLACE OF BURIAL		CITY		STATE		COUNTRY		FUNERAL HOME	
APRIL 6, 1968		MEMPHIS		TENNESSEE		UNITED STATES		AMERICA		JAMES EARL RAY FUNERAL HOME	
DATE OF REPORT		PLACE OF REPORT		CITY		STATE		COUNTRY		REPORTING OFFICER	
APRIL 4, 1968		MEMPHIS		TENNESSEE		UNITED STATES		AMERICA		DR. JAMES EARL RAY	

BUREAU V. 5

SEP 4 1956

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INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08221

## 8245 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>La Plata</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>4 Jackson Rd.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CAROL CATHERINE CARPENTER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>AUG 9 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 5, 1903</u>	9. AGE last birthday <u>53</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Nichols</u>				14. MOTHER'S MAIDEN NAME <u>Lillie Moon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Charles B. Carpenter Indian Head, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
782.4 IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				<u>Cardiac failure</u>		<u>10 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>obesity</u>		<u>10 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-7</u> , 19 <u>56</u> , to <u>8-9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>8-8</u> , 19 <u>56</u> , and that death occurred at <u>7:45</u> PM, from the causes and on the date stated above.							
SIGNATURE <u>J. P. Johnson</u>				ADDRESS (Street, city, town, state) <u>LA PLATA, Md.</u>		DATE SIGNED <u>8-9-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-12-56</u>		NAME OF CEMETERY OR CREMATORY <u>Pisgah Cem (M.E.)</u>		LOCATION (City, town, or county) (State) <u>Pisgah, Md.</u>	
24. REC'D BY REGISTRAR <u>AUG 15 1956</u>		REGISTRAR'S SIGNATURE <u>Julia Pacey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u>			
DATE		ADDRESS <u>Waldorf, Md.</u>					

A34

# DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Form No. 10

1. DECEASED'S NAME (Last, first, middle)

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. MARITAL STATUS

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF CHURCH

17. SIGNATURE OF OTHER

18. SIGNATURE OF

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BUREAU V. 3

AUG 15 1956

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08222 106  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES CO. MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CORR ISLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MARLOW HEIGHTS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MELVIN W. CHEVILLE</b>		4. DATE OF DEATH <b>8 4 19 56</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-23 32</b>
9. AGE (In years and birth day) <b>32</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTH PLACE (State or foreign country) <b>Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>EDWARD B. CHEVILLE</b>		14. MOTHER'S MAIDEN NAME <b>INEZ C. BLANKENSHIP</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>579-20-1182</b>	
17. INFORMANT <b>MRS. NAOMI M. CHEVILLE</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DROWNING</b> 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>FELL FROM BOAT</b> DUE TO (c) <b>8-4-56</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>E. J. EDELEN</b>		DATE SIGNED <b>8-6-56</b>	
EXAMINER'S NAME (Type) <b>E. J. EDELEN M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8-9-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>		22d. LOCATION (City, town, or county) (State) <b>SUITLAND, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers C.</b>		24a. REC'D BY REGISTRAR <b>Aug 8 1956</b>	
ADDRESS <b>WASH. D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. Oley Prince</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

208

AUG 8 1956

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08223

8247 **CERTIFICATE OF DEATH**

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>La Plata</u> (en-route)				TOWN <u>Cobb Island</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>JOHN P DENHAM</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>8-27-56</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>		<b>8. DATE OF BIRTH</b> <u>8-18-1902</u>	
						<b>9. AGE last birthday</b> <u>54</u> yrs.	
						<b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Electric Plater</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington D.C.</u>	
<b>13. FATHER'S NAME</b> <u>Albert V. Denham</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>579-40-0109</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Helen V. Denham Cobb Island Md.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>IMMEDIATE CAUSE (A)</b> <u>420.1</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>8-27-56</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>							
<b>(B) DUE TO</b>							
<b>(C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>8-27-56</u>, to <u>8-27-56</u>, that I last saw the deceased alive on <u>8-27-56</u>, and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>E. J. Madelin</u>				<b>DATE SIGNED</b> <u>8-27-56</u>			
<b>ADDRESS (Street, city, town, state)</b> <u>La Plata Md.</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>8-30-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. Lincoln Cem.</u>		<b>LOCATION (City, town or county) (State)</b> <u>Washington D.C.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>AUG 29 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Julia Posey</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. Chambers</u>		<b>ADDRESS</b> <u>517-11th St. S.E.</u>	

BUREAU Y. S.

AUG 29 1956

RECEIVED

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1956

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
JAMES HENRY HUNTER, JR.		Male		38		White		August 28, 1956		Baltimore, Maryland	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CORONER	
None		Myocardial Infarction		Natural		[Signature]		[Signature]		[Signature]	
13. PLACE OF BIRTH		14. DATE OF BIRTH		15. MARITAL STATUS		16. EDUCATION		17. RELIGION		18. SOCIAL SECURITY NUMBER	
Baltimore, Maryland		August 10, 1918		Married		High School		Catholic		[Number]	
19. PREVIOUS RECORDS		20. OTHER INFORMATION		21. REMARKS		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF CORONER	
None		None		None		[Signature]		[Signature]		[Signature]	

1. This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause and manner of death. It is to be filed with the local health department or the State Department of Health, Baltimore, Maryland.

2. The certificate is to be filled out in duplicate. One copy is to be retained by the local health department or the State Department of Health, Baltimore, Maryland. The other copy is to be retained by the physician or coroner who has examined the body of the deceased.

3. The certificate is to be filled out in English. It may be filled out in Spanish or French if the deceased was born in a Spanish-speaking or French-speaking country.

4. The certificate is to be filled out in the following order: 1. Name of deceased, 2. Sex, 3. Age, 4. Race, 5. Date of death, 6. Place of death, 7. Occupation, 8. Cause of death, 9. Manner of death, 10. Signature of registrar, 11. Signature of physician, 12. Signature of coroner, 13. Place of birth, 14. Date of birth, 15. Marital status, 16. Education, 17. Religion, 18. Social security number, 19. Previous records, 20. Other information, 21. Remarks, 22. Signature of registrar, 23. Signature of physician, 24. Signature of coroner.

5. The certificate is to be filled out in the following order: 1. Name of deceased, 2. Sex, 3. Age, 4. Race, 5. Date of death, 6. Place of death, 7. Occupation, 8. Cause of death, 9. Manner of death, 10. Signature of registrar, 11. Signature of physician, 12. Signature of coroner, 13. Place of birth, 14. Date of birth, 15. Marital status, 16. Education, 17. Religion, 18. Social security number, 19. Previous records, 20. Other information, 21. Remarks, 22. Signature of registrar, 23. Signature of physician, 24. Signature of coroner.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8248

## CERTIFICATE OF DEATH

08224

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LA PLATA</u>		LENGTH OF STAY (in this place) <u>6 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Indian Head</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Mem. Hospt</u>				STREET ADDRESS (If rural give location) <u>34 Carroll Dr Riverside 8-4941</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>HENRY</u> (First) <u>M.</u> (Middle) <u>GARDNER</u> (Last) <u>GARDNER</u>				<b>4. DATE OF DEATH</b> (Month) <u>Aug</u> (Day) <u>4</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b> <u>DEC 23, 1885</u>	<b>9. AGE last birthday</b> <u>70</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Tool Maker Brown &amp; Sharp Co.</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Rhode Island</u>		
<b>13. FATHER'S NAME</b> <u>Henry J. Gardner</u>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <u>035-10-7919</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>HOSPITAL Records</u>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>14a. IMMEDIATE CAUSE (A)</b> <u>Cardio Renal Disease</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Indefinite</u>	
<b>14b. ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Hypertensive Pneumonia</u>						<u>19 Weeks</u>	
<b>14c. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Atherosclerosis General</u>						<u>Indefinite</u>	
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>None</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>6-15-56</u> to <u>8-4-56</u>, 19<u>56</u>, that I last saw the deceased alive on <u>8-4-56</u>, 19<u>56</u>, and that death occurred at <u>Indian Head Md</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>James E. Chambers M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Indian Head Md 8-4-56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>8-8-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Lanternet Cem.</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Lanternet Rd. Indian Head Md</u>	
<b>24. REC'D BY REGISTRAR</b> <u>AUG 7 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Julia F. Pasy</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W.W. Chambers Co</u>		<b>ADDRESS</b> <u>517-11th St S.E.</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF BURIAL

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF JUDGE

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF COURT

21. SIGNATURE OF STATE

22. SIGNATURE OF NATION

23. SIGNATURE OF WORLD

24. SIGNATURE OF UNIVERSE

25. SIGNATURE OF GOD

26. SIGNATURE OF DEVIL

27. SIGNATURE OF ANGELS

28. SIGNATURE OF DEMONS

29. SIGNATURE OF SAINTS

30. SIGNATURE OF SINNERS

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80. SIGNATURE OF SHAME

81. SIGNATURE OF PRAISE

82. SIGNATURE OF REPROACH

83. SIGNATURE OF FAME

84. SIGNATURE OF OBSCURITY

85. SIGNATURE OF RESPECT

86. SIGNATURE OF CONTEMPT

87. SIGNATURE OF ADMIRATION

88. SIGNATURE OF DERISION

89. SIGNATURE OF VENERATION

90. SIGNATURE OF CONDEMNATION

91. SIGNATURE OF GLORIFICATION

92. SIGNATURE OF DAMNATION

93. SIGNATURE OF LIFE EVERLASTING

94. SIGNATURE OF DEATH EVERLASTING

95. SIGNATURE OF HEAVEN

96. SIGNATURE OF HELL

97. SIGNATURE OF PARADISE

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281. SIGNATURE OF LIMBO

282. SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08225

8249

CERTIFICATE OF DEATH

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <u>CHARLES</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hosp.</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCIS J. HIGDON</u>			4. DATE OF DEATH Month Day Year <u>Aug 10 1956</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-1873</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>83</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Powder Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Charles County</u>	
13. FATHER'S NAME <u>Thomas Higdon</u>			14. MOTHER'S MAIDEN NAME <u>Mary E. Franklin</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Wilson W. Wright Accokeek, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Collapse</u> <u>157x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of pancreas</u> DUE TO (c) <u>1 year</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 1956</u> to <u>Aug 10 1956</u> that I last saw the deceased alive on <u>17 Aug 1956</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>[Signature]</u> M.D.			DATE SIGNED <u>La Plata Md.</u>		
PHYSICIAN'S NAME (Type) <u>A. O. Wooddy M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Marbury Cem.</u>	
22d. LOCATION (City, town, or county) <u>Marbury, Md.</u>		22e. (State)		22f. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u>			ADDRESS <u>Waldorf, Md.</u>		
24a. REC'D BY REGISTRAR <u>AUG 21 1956</u>			24b. REGISTRAR'S SIGNATURE <u>Julia P. [Signature]</u>		

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8250

## CERTIFICATE OF DEATH

118226

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>La Plata</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Hill Top</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Rhy Memorial Hosp</i>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>William N. Johnson</i>				<b>4. DATE OF DEATH</b> (Month) <i>8</i> (Day) <i>30</i> (Year) <i>1956</i>			
<b>5. SEX</b> <i>M</i>	<b>6. COLOR OR RACE</b> <i>W</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED.</b> (Specify) <i>Married</i>	<b>8. DATE OF BIRTH</b> <i>May 15, 1923</i>		<b>9. AGE last birthday</b> <i>63</i> yrs.		<b>IF UNDER 1 YEAR</b> Months Days
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Farming</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Md.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.</i>	
<b>13. FATHER'S NAME</b> <i>William Johnson</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Ellen Mason</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i>		<b>16. SOCIAL SECURITY NO.</b> <i>none</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Mac Willett Clinton Md</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>331X IMMEDIATE CAUSE (A)</b> <i>Cerebral hemorrhage</i>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>8-8-56</i>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <i>Hypertension</i>				<i>2 1 1</i>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>8-8-56</i>, to <i>8-30-56</i>, 19<i>56</i>, that I last saw the deceased alive on <i>8-29-56</i>, 19<i>56</i>, and that death occurred at <i>1:15</i> P.M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>E. E. Edelen M.D.</i>				<b>DATE SIGNED</b> <i>8-30-56</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Removal</i>		<b>DATE THEREOF</b> <i>Sept 1, 1956</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Old Durham</i>		<b>LOCATION (City, town, or county)</b> <i>Ironides Md</i>	
<b>24. REC'D BY REGISTRAR</b> <i>SEP 5 1956</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Mrs. F. Wells Poyess</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Hunt Funeral Home</i>		<b>ADDRESS</b> <i>undisclosed</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8251

## CERTIFICATE OF DEATH

08227

Reg. Dist. No.

100  
282

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HUGHESVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HUGHESVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>RURAL</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>PATTIE ELIZABETH KERSHAW</b>		4. DATE OF DEATH Month Day Year <b>AUGUST 27 1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/18/1869</b>
9. AGE (In years last birthday) yrs. <b>87</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HUSBAND</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JEREMIAH DUDLEY</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE ALVEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>LUCILLE K. NORRIS</b>		Address <b>-/LEONARDTOWN, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>5-yr</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1956</b> to <b>Aug 27 1956</b> , that I last saw the deceased alive on <b>Aug 19 1956</b> , and that death occurred at <b>9:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. Roy Guyther</b>		M.D. <b>Mechanicsville</b> DATE SIGNED <b>8/27/56</b>	
PHYSICIAN'S NAME (Type) <b>J. ROY GUYTHER, M.D.</b>		<b>MECHANICSVILLE, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>8/29/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>OLDFIELD CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>HUGHESVILLE, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. B. Robinson</b>		ADDRESS <b>LEONARDTOWN, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>8/28/56</b>		24b. REGISTRAR'S SIGNATURE <b>John D. Houser</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08228<sup>100</sup>  
Reg. Dist. No. 282

8252

1. PLACE OF DEATH a. COUNTY <u>CHARLES CO</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ST MARYS</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HUGHESVILLE</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>U.S. NAVY PATUXENT RIVER</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Highway #5</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>DONALD EUGENE MARTIN</u>			4. DATE OF DEATH Month Day Year <u>8 5 1956</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-29-33</u>		9. AGE (In years last birthday) <u>22</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. NAVY</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>CALIFORNIA</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>JOHN EDWIN MARTIN</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>11-8-51 to 8-5-56</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>U.S. NAVY RECORDS</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>823X</u> DUE TO <u>Crushed Chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>8-5-56</u> DUE TO <u>Auto accident - driver</u> (c) <u>8-5-56</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>DRIVER OF AUTOMOBILE WHICH LEFT HIGHWAY AND OVERTURNED</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>1:15</u> <u>AUG 5</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STREET</u>	
20f. (City or town) <u>HUGHESVILLE, Charles</u>		20g. (County) <u>MD.</u>		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>E. E. Edelen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-6-56</u>	
EXAMINER'S NAME (Type) <u>E. E. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		22b. DATE THEREOF <u>8/7/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kansas City, Missouri</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. B. Bohman</u>		ADDRESS <u>Leonardtwn, Md.</u>		24a. REC'D BY REGISTRAR <u>8/7/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Julius Banks</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAKING STATE DEPARTMENT OF HEALTH-BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
AUG 8 1956  
BUREAU V. S.

Form with multiple sections for medical examination, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint, illegible markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08229

8253

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH o. COUNTY <i>Charles Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wellcome</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wellcome</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>EDNA</i> First <i>MATTHEWS</i> Middle <i>MATTHEWS</i> Last		4. DATE OF DEATH Month <i>8</i> Day <i>14</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 14 1908</i>
9. AGE (In years last birthday) <i>55</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>AW</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>md</i>	
11. BIRTHPLACE (State or foreign country) <i>md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Hall</i>		14. MOTHER'S MAIDEN NAME <i>Rosie Duckett</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Brooks Matthews Wellcome</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro Vascular Accident</i> <i>331 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO (c) <i>Nephritis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8-11-56</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>54</i> to <i>8-14</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>12</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>E. J. EDELEN</i> M.D.			
PHYSICIAN'S NAME (Type) <i>E. J. EDELEN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>8/18/56</i>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>St Ignatius</i>		<i>Hill top md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archibald Inc La Plata</i>		24a. REC'D BY REGISTRAR DATE <i>8/16/56</i>	
24b. REGISTRAR'S SIGNATURE <i>James H. Pary</i>			

# CERTIFICATE OF DEATH

1956

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>1911</i></p>	
<p>5. PLACE OF BIRTH <i>City, State</i></p>		<p>6. OCCUPATION <i>Teacher</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>1935</i></p>	
<p>9. NAME OF SPOUSE <i>Jane Doe</i></p>		<p>10. DATE OF DEATH <i>Aug 20 1956</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. SIGNATURE OF DECEASED <i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESS <i>John Doe</i></p>	
<p>15. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>		<p>16. SIGNATURE OF CORONER <i>John Doe</i></p>	
<p>17. SIGNATURE OF JUDGE <i>John Doe</i></p>		<p>18. SIGNATURE OF CLERK <i>John Doe</i></p>	

BUREAU Y. 1

AUG 20 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10231

Reg. Dist. No. 100

10830 Items 13, 14, File G205 10-29-56 et

1. PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata, Md.</b> c. LENGTH OF STAY in lb <b>Physicians' Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>478-3</b> d. STREET ADDRESS <b>17 N St., S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Mitchell</b> Last <b>Mitchell</b>		4. DATE OF DEATH Month <b>8</b> Day <b>22</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-15-1902</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b>	IF UNDER 24 HRS. Hours <b>53</b> Min. <b>53</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Concrete Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Address</b>	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Cervical Vertebrae - Cord Severance</b> DUE TO (b) <b>Automobile Accident</b> DUE TO (c) <b>825x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in auto involved in accident</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>8-19-56</b> p. m. <b>8-19-56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Hughesville, Charles, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>E. J. Edelen</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>E. J. Edelen, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>8-27-56</b>		22b. DATE THEREOF <b>27-27-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Shoodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Wash. DC</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis Funeral Home</b>		24a. REC'D BY REGISTRAR <b>Oct. 24, 1956</b>	
ADDRESS <b>384 R St.</b>		24b. REGISTRAR'S SIGNATURE <b>Julia Carey</b>	

1956 23 OCT

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8257

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG202 9-1-56 et.

08233

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Dc</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Phy Manu Hosp</u>		d. STREET ADDRESS <u>Washington Dc</u>	
3. NAME OF DECEASED (Type or print) <u>Mitchell</u> First <u>MITCHELL</u> Middle <u>RICHARD</u> Last <u>RICHARD</u>		4. DATE OF DEATH <u>8</u> Month <u>22</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15, 1902</u>
9. AGE (In Years last birthday) <u>54</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Concrete worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.E.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Ethel M Mitchell Washington Dc</u>	
17. INFORMANT <u>Ethel M Mitchell Washington Dc</u>		Address <u>Washington Dc</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Phac. Cerv. Vert &amp; Cord Severance</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Auto accident</u> DUE TO (c) <u>Auto accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8-19-56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>8-19-56</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>8 19 1956</u> Hour <u>11</u> a. m. <u>11</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St 5</u>		20f. (City or town) <u>Hyphous Ches Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. F. Edelen</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. F. EDELEN M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-23-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/27/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Washington Dc.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Lewis Harris La Plata</u>		ADDRESS <u>La Plata</u>	
24a. REC'D BY REGISTRAR <u>8/27/56</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. Boren</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		TEMPERATURE		PULSE		RESPIRATION	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION		COUNTRY OF EXAMINATION		STATE OF EXAMINATION	

RECEIVED  
AUG 29 1956  
BUREAU X. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

Item 20 Film G202 9-13-56 ems										8254										M.D. STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08230									
										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 100																			
1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Charles</b>																													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>										c. LENGTH OF STAY IN 1b <b>Life</b>										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>																			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)										d. STREET ADDRESS <b># 8 Couden Rd.</b>										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <b>THOMAS E PEARSON</b>										4. DATE OF DEATH <b>8 11 1956</b>																													
5. SEX <b>M</b>										6. COLOR OR RACE <b>White</b>										7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>																			
8. DATE OF BIRTH <b>Dec 4, 1950</b>										9. AGE (In years last birthday) <b>5</b> yrs.										10. IF UNDER 1 YEAR Months Days Hours Min.																			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)										10b. KIND OF BUSINESS OR INDUSTRY										11. BIRTH PLACE (State or foreign country) <b>Charles Co</b>																			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>																																							
13. FATHER'S NAME <b>Raymond E Pearson</b>										14. MOTHER'S MAIDEN NAME <b>Grace E. Weaver</b>																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>										16. SOCIAL SECURITY NO.										17. INFORMANT <b>Raymond Pearson Indian Head Md</b> Address																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ELECTROCUTION</b> 9140 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										INTERVAL BETWEEN ONSET AND DEATH																													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Electrocuted on home-made fence</b>																													
20c. TIME OF INJURY Month, Day, Year <b>7:00 a.m. 8/11/56 19</b>										20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Yard (Home)</b>																			
20f. (City or town) <b>Indian</b> (County) <b>Charles</b> (State) <b>Md.</b>																																							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .																																							
ACTUAL SIGNATURE <b>Paul F. Guerin</b>										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED <b>8-12-56</b>																			
EXAMINER'S NAME (Type) <b>PAUL F. GUERIN</b>										ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>																													
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																																							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>										22b. DATE THEREOF <b>8/14/56</b>										22c. NAME OF CEMETERY OR CREMATORY <b>St Pauls Pines</b>																			
22d. LOCATION (City, town, or county) <b>Waldorf</b> (State) <b>Md.</b>																																							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archibut Inc</b>										ADDRESS <b>La. plate Md</b>										24a. REC'D BY REGISTRAR <b>8/16/56</b>																			
24b. REGISTRAR'S SIGNATURE <b>Julia H. Paray</b>																																							

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

*[Faint, mostly illegible handwritten text and printed form fields, including sections for cause of death, manner of death, and examiner information.]*

BUREAU Y. B.

AUG 20 1956

RECEIVED

8255

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

105

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Plains, Md.</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Plains</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Peterson</b> Last <b>Peterson</b>				4. DATE OF DEATH Month <b>8</b> Day <b>30</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1892</b>		9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months <b>64</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Minor</b>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Knut Peterson</b>				14. MOTHER'S MAIDEN NAME <b>Emma Jensen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Ernest H. Peterson</b> Address <b>Radio md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>11 1/2 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>William J. Kurz, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William J. Kurz, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Sept 3, 1956</b>		<b>St Paul Cemetery</b>		<b>Badin</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home and Sons, Inc.</b>				24a. REC'D BY REGISTRAR <b>SEP 5 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mr. L. M. M...</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HARRIS		45		Male		White		SEP 3 1956	
RESIDENT OF		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL EXAMINER'S SIGNATURE	
1000 N. E. ST.		HOSPITAL		HEART DISEASE		NATURAL		J. H. HARRIS	
BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.		BALTIMORE, MD.	
DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
SEP 3 1956		SEP 3 1956		10:00 AM		HOSPITAL		NATURAL	
PLACE OF BIRTH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL EXAMINER'S SIGNATURE	
BALTIMORE, MD.		BALTIMORE, MD.		HEART DISEASE		NATURAL		J. H. HARRIS	
DATE OF BIRTH		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
SEP 3 1956		SEP 3 1956		10:00 AM		HOSPITAL		NATURAL	

BUREAU V. A.

SEP 5 1956

RECEIVED

8256

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

105

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived; If Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <i>VERA</i> Middle <i>MAE</i> Last <i>Proctor</i>				4. DATE OF DEATH Month <i>8</i> Day <i>31</i> Year <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-18-55</i>		9. AGE (In years last birthday) <i>1</i> yrs.	IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i>	IF UNDER 24 HRS. Hours <i>1</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Lester Proctor</i>				14. MOTHER'S MAIDEN NAME <i>Catherine Queen</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Lester Proctor Waldorf Md</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inf. Diarrhea</i> 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>8-30-31-56</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. J. Edelen</i> EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED <i>8-31-56</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>Sept 4, 1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Peter's</i>		22d. LOCATION (City, town, or county) (State) <i>Waldorf Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home Waldorf</i>				ADDRESS <i>Waldorf Md</i>			
24. RECEIVED BY REGISTRAR <i>Mr. H. Monroe</i>				25. REGISTRAR'S SIGNATURE <i>Mr. H. Monroe</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF MEDICAL EXAMINERS' CERTIFICATE OF DEATH

**RECEIVED**  
SEP 5 1956  
BUREAU V. R.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. JONES		45		M		W		10/10/55		NEW YORK	
RESIDENT OF		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
NEW YORK		Carpenter		High School		Married		Heart Disease		Natural	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO CITY		DATE OF ENTRY INTO COUNTY	
10/10/10		NEW YORK		10/10/50		10/10/50		10/10/50		10/10/50	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
10/10/55		NEW YORK		10/10/55		NEW YORK		10/10/55		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
10/10/55		NEW YORK		10/10/55		NEW YORK		10/10/55		NEW YORK	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8258  
CERTIFICATE OF DEATH

11823400  
282

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HUGHESVILLE</b>				c. LENGTH OF STAY IN 1b <b>11 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HUGHESVILLE</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS <b>RURAL</b>			
3. NAME OF DECEASED (Type or print) First <b>LUCY</b> Middle <b>ELMORE</b> Last <b>RIDGELL</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>22</b> Year <b>1956</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 19, 1874</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>AUSTIN RIDGELL</b>			
14. MOTHER'S MAIDEN NAME <b>SUSAN R. HAMMETT</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. -----				17. INFORMANT Address <b>Mrs. RUTH BRAGG - HUGHESVILLE, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma (Basal cell) face</b> <b>191X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 1950</b> to <b>Aug 22, 1956</b> , that I last saw the deceased alive on <b>Aug 22, 1956</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>MECHANICSVILLE, MD</b> DATE SIGNED <b>8/23/56</b>							
ACTUAL SIGNATURE <b>J. Roy Guyther</b> M.D.				PHYSICIAN'S NAME (Type) <b>J. ROY GUYTHER, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>8/25/ 56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAELS CEMETERY</b>	
22d. LOCATION (City, town, or county) (State) <b>RIDGE, MARYLAND</b>				23. FLUNERAL DIRECTOR'S SIGNATURE <b>B. B. Robinson</b> ADDRESS <b>LEONARDTOWN, Md.</b>			
24a. REC'D BY REGISTRAR DATE <b>8/28/56</b>				24b. REGISTRAR'S SIGNATURE <b>Julia P. Hays</b>			

CERTIFICATE OF DEATH

8252

NAME OF DECEASED JAMES H. HARRIS		SEX MALE		AGE 45	
PLACE OF BIRTH BALTIMORE, MD		DATE OF BIRTH JAN 15 1910		TIME OF BIRTH 10:30 AM	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
DATE OF DEATH AUG 20 1956		TIME OF DEATH 11:00 AM		PLACE OF DEATH HOME	
SIGNATURE OF DECEASED (Signature)		SIGNATURE OF WITNESS (Signature)		SIGNATURE OF PHYSICIAN (Signature)	
SIGNATURE OF CORONER (Signature)		SIGNATURE OF JURY (Signature)		SIGNATURE OF STATE'S ATTORNEY (Signature)	
SIGNATURE OF COUNTY CLERK (Signature)		SIGNATURE OF CITY CLERK (Signature)		SIGNATURE OF HEALTH COMMISSIONER (Signature)	

BUREAU V. S.

AUG 29 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08235											
8259 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Items 3, 13 Film 201 9-19-56 et											
Reg. Dist. No. 100											
1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Charles</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryantown</i>			c. LENGTH OF STAY IN 1b <i>3 month</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bryantown</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>MARY ELIZABETH ROBERTSON</i>					DATE OF DEATH Month <i>8</i> Day <i>5</i> Year <i>1956</i>						
5. SEX <i>F</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-1-56</i>		9. AGE (In years last birthday) yrs. <i>3</i> Months <i>4</i> Days <i>4</i> Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>					10b. KIND OF BUSINESS OR INDUSTRY <i>MD</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>James Robertson</i>					14. MOTHER'S MAIDEN NAME <i>Christine Young</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>					16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Christine Young</i> Address <i>Bryantown</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumo Mononucleosis</i> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO (c) <i></i>										INTERVAL BETWEEN ONSET AND DEATH <i>8-4-56</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>E. J. EDELEN</i> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <i>E. J. EDELEN MD</i>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Aug 9 1956</i>					22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>St Marys</i>		22d. LOCATION (City, town, or county) (State) <i>Bryantown MD</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hunt Funeral Home</i>					ADDRESS <i>MD</i>		24a. REC'D BY REGISTRAR <i>DATE AUG 7 1956</i>		24b. REGISTRAR'S SIGNATURE <i>John F. Poreys</i>		

STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, and cause of death. The form is filled out with handwritten information, including a signature and date.

RECEIVED  
AUG 7 1956  
BUREAU V. 3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08236

Reg. Dist. No.

8260

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>		c. LENGTH OF STAY in 1b <b>Unk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>ROBERT</b> <b>SMITH</b> <b>SWANN</b>		4. DATE OF DEATH Month <b>8</b> Day <b>17</b> Year <b>1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-20-1872</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>St Mary's County</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philip Swann</b>		14. MOTHER'S MAIDEN NAME <b>Georgeanna Mattingly</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs Robert P. Bowling</b>		Address <b>Wicomico, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO <b>CEN ART SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>8-17-56</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>E. J. EDELEN</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>E. J. EDELEN</b>		DATE SIGNED <b>8-18-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-20-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Rest Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>La Plata, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home</b>		ADDRESS <b>Waldorf, Md.</b>	
24a. REC'D BY REGISTRAR <b>AUG 21 1956</b>		24b. REGISTRAR'S SIGNATURE <b>M. L. Monroe</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		TIME OF EXAMINATION		FEE		REMARKS	

BUREAU V. S.

AUG 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the poppers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8261

## CERTIFICATE OF DEATH

Reg. Dist. No.

08237  
100

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>William (Willie)</b> <b>J.</b> <b>Thomas</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>11</b> , Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 27, 1883</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b>19</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>La Plata, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Madison I. Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Theresa Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William A. Thomas</b> <b>3054 Vista St. N.E. Washington, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1954</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>La Plata, Maryland</b>				20g. (County) (State)			
21. I certify that I attended the deceased from <b>8-11</b> , <b>1956</b> , pronounced dead, that I last saw the deceased alive on <b>12</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>La Plata, Maryland</b> DATE SIGNED <b>8-11-56</b>							
ACTUAL SIGNATURE <b>E. J. Edelen, M.D.</b>				PHYSICIAN'S NAME (Type) <b>E. J. Edelen, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>8-14-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph</b>		22d. LOCATION (City, town, or county) (State) <b>Pandoret Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Gubins</b>				ADDRESS <b>8702-12th St.</b>		24a. REC'D BY REGISTRAR <b>Julia H. Pacey</b>	
24b. REGISTRAR'S SIGNATURE				DATE <b>8/15/56</b>			

CERTIFICATE OF DEATH

2501

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		45		JAN 15 1906		BALTIMORE		MARYLAND		UNITED STATES			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
LABORER		HEART DISEASE		NATURAL		JUL 10 1956		BALTIMORE		MARYLAND		UNITED STATES			
EDUCATION		RELIGION		MARRIAGE		SINGLE		DATE OF MARRIAGE		CITY		STATE		COUNTRY	
HIGH SCHOOL		METHODIST		MARRIED											
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
JAMES H. HARRIS		MARY J. HARRIS		LABORER		HOUSEWIFE		JAN 15 1880		JAN 15 1880		BALTIMORE		BALTIMORE	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH	
FATHER'S CITY		MOTHER'S CITY		FATHER'S STATE		MOTHER'S STATE		FATHER'S COUNTRY		MOTHER'S COUNTRY		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
BALTIMORE		BALTIMORE		MARYLAND		MARYLAND		UNITED STATES		UNITED STATES		BALTIMORE		BALTIMORE	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
JAN 15 1880		JAN 15 1880		BALTIMORE		BALTIMORE									
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
FATHER'S CITY		MOTHER'S CITY		FATHER'S STATE		MOTHER'S STATE		FATHER'S COUNTRY		MOTHER'S COUNTRY		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
BALTIMORE		BALTIMORE		MARYLAND		MARYLAND		UNITED STATES		UNITED STATES		BALTIMORE		BALTIMORE	

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CERTIFICATE OF DEATH

Reg. Dist. No. 08238 905

1. PLACE OF DEATH a. COUNTY <u>Charles County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>				c. LENGTH OF STAY IN 1b <u>UNK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf Rural</u>			
				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>GRACE</u> <u>JOHANA</u> <u>ULLMANN</u>				4. DATE OF DEATH Month Day Year <u>August</u> <u>22</u> , <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-13-1888</u>	
				9. AGE (In years last birthday) yrs. <u>68</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Charles County, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Anton Winkler</u>				14. MOTHER'S MAIDEN NAME <u>Emily Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
				17. INFORMANT Address <u>Mrs Barbara Duffy Waldorf, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> (c) <u>Atherosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>1 Day</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>6-20</u> , 19 <u>56</u> , to <u>6-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-22</u> , 19 <u>56</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard H. Dobson</u> M.D.				DATE SIGNED <u>Briney, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-25-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Joseph's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pomfret, Md.</u>	
23. BURIAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u>				ADDRESS <u>Waldorf, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8/27/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>M. L. Monroe</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES J. JONES		AGE 45		SEX Male		RACE White		DATE OF DEATH 10-27-1956		PLACE OF DEATH Home	
MARRIAGE Married		EDUCATION High School		OCCUPATION Salesman		BIRTH DATE 11-1-1911		BIRTH PLACE Maryland		BIRTH DATE 11-1-1911	
FATHER'S NAME JAMES J. JONES		MOTHER'S NAME JANE J. JONES		FATHER'S BIRTH DATE 11-1-1911		MOTHER'S BIRTH DATE 11-1-1911		FATHER'S BIRTH PLACE Maryland		MOTHER'S BIRTH PLACE Maryland	
PREVIOUS DEATHS None		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		UNDERLYING CAUSE Coronary Artery Disease		MORBIDITY None	
DATE OF DEATH 10-27-1956		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home		ATTENDING PHYSICIAN J. J. Jones, M.D.		CERTIFYING PHYSICIAN J. J. Jones, M.D.		SIGNATURE J. J. Jones	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# 8263 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08239

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 18: G202 9-5-56

Reg. Dist. No.

106

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Indian Head</b>				c. LENGTH OF STAY IN 1b <b>Indian Head</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>Indian Head</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>FRANCIS</b> Middle <b>W.</b> Last <b>WEDDING</b>				4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-2-32</b>	
9. AGE (In years last birthday) <b>24</b> yrs.		IF UNDER 1 YEAR Months <b>24</b> Days <b>7</b> Hours <b>19</b> Min. <b>56</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumbing</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Repair</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Joseph Wedding</b>		14. MOTHER'S MAIDEN NAME <b>Maude Wynn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>XXXX Korea 217 28 8725</b>		17. INFORMANT <b>Joseph Wedding</b>		Address <b>Indian Head, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC BRONCHITIS</b> DUE TO <b>EARLY BRONCHO PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>FATTY INFILTRATION OF LIVER</b> (c) <b>FATTY INFILTRATION OF LIVER</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>8/8/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-11-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Rest</b>		22d. LOCATION (City, town, or county) (State) <b>La Plata, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home</b>				ADDRESS <b>Waldorf, Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 15 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Mrs. Oley Price</b>							

STATE DEPARTMENT OF HEALTH--BALTIMORE, MD

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